

**Beneficiary Information**

1. Beneficiary Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
3. Beneficiary ID #: \_\_\_\_\_ 4. Beneficiary Date of Birth: \_\_\_\_\_ 5. Beneficiary Gender: \_\_\_\_\_

**Prescriber Information**

6. Prescriber Name: \_\_\_\_\_ NPI #: \_\_\_\_\_  
Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
7. Requester Contact Information: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Drug Information**

8. Drug Name: \_\_\_\_\_ 9. Dose: \_\_\_\_\_ 10. Directions: \_\_\_\_\_  
11. Length of Therapy: \_\_ up to 30 days \_\_ 60 days \_\_ 90 days \_\_ 120 days \_\_ 180 days \_\_ 365 days \_\_ Other: \_\_\_\_\_

**Clinical Information**

**Request for Crohn's Disease (Adult):**

1. Does the beneficiary have a diagnosis of moderate to severe Crohn's Disease? Yes \_\_\_ No \_\_\_
2. Is the beneficiary 18 years of age or older? Yes \_\_\_ No \_\_\_
2. Is the beneficiary on another injectable biologic immunomodulator? Yes \_\_\_ No \_\_\_
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes \_\_\_ No \_\_\_
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes \_\_\_ No \_\_\_
5. Has the beneficiary had a trial and failure of Humira, or a clinical reason beneficiary cannot try Humira? Yes \_\_\_ No \_\_\_

**Request for Ulcerative Colitis (Adult):**

1. Does the beneficiary have a diagnosis of ulcerative colitis? Yes \_\_\_ No \_\_\_
2. Is the beneficiary 18 years of age or older? Yes \_\_\_ No \_\_\_
3. Is the beneficiary on another injectable biologic immunomodulator? Yes \_\_\_ No \_\_\_
4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes \_\_\_ No \_\_\_
5. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes \_\_\_ No \_\_\_
6. Has the beneficiary had a trial and failure of Humira, or a clinical reason beneficiary cannot try Humira? Yes \_\_\_ No \_\_\_

**Request for FDA Approved Diagnosis Not Listed Above:**

1. Diagnosis: \_\_\_\_\_
2. Is the beneficiary on another injectable biologic immunomodulator? Yes \_\_\_ No \_\_\_
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes \_\_\_ No \_\_\_
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes \_\_\_ No \_\_\_

Signature of Prescriber: \_\_\_\_\_

Date: \_\_\_\_\_

**\*Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

**Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406**